Mortality Review

Module VI

Instructor's Guide

Length of Session: 1 to 1.5 hours

Intended Audience: Regional center staff; Mortality Review Committee Members; Members of the regional center's Risk Management, Assessment, and Planning committee; health care providers

Class Size: Limited only by room capacity

Training Materials: Power Point presentation (or transparencies): *Mortality Review*

LCD projector or Overhead projector

Flipchart and markers (as desired)

Methods: Lecture; instructor guided discussion; interactive

Course Outline

I. Welcome and Introductions

II. Introduction to Mortality Review

III. Designing Mortality Review Systems

IV. Potential Pitfalls

V. Summary and Closing

Mortality Review

Module VI

Learning Objectives

At the conclusion of this module, participants will:

1. Describe the Mortality Review process.
2. Identify reasons for completing mortality reviews.
3. Describe the basic elements of a mortality review system.
4. Identify potential limitations of mortality review systems.

Mortality Review

Script for Instructor	*Suggestions for Instructor*
Slide 1: **Mortality Review** The goal of mortality review is to learn from a person's death, to discover if the same or similar situations may affect others in the future, and to improve overall quality of care. Assessing incompetence, intentional injury or violation of rights, rules, or regulations **is not** the intended goal of mortality review. These issues, if present, are generally addressed through other administrative means. Deaths, regardless of where or when they occur, must be reported as Special Incidents. In addition, regional centers have an obligation to develop and implement 'a process for reviewing medical records and coroner reports, as appropriate, associated with special incidents to ensure that appropriate medical attention was sought and/or given" (Title 17, Article 2, 54327.2, (b) (5). This must be covered in the regional center's Risk Management and Mitigation Plan.	*Start the Power Point presentation or display the title overhead transparency.* *Ask participants to identify actions typically taken at this regional center following a death.* *Ask participants to identify how their regional center could benefit from looking at deaths as an opportunity to improve services.*

Script for Instructor	*Suggestions for Instructor*
Slide 2: **Benefits of Mortality Review** In a mortality review system, factual information is reviewed to determine ways to improve the quality of future services. Benefits of mortality review systems include: • Improved monitoring of quality of care • Development of a mortality database • Improved timeliness of documentation and reporting • Increased attention to quality across all service areas • Enhanced ability to respond to external inquiry/scrutiny (licensing, media, etc.)	
Slide 3: **Organizational Support** There are specific organizational factors that support the mortality review process. Foremost is an organizational culture supportive of risk reduction and safety. When this culture is present, the organization utilizes mortality review as a preventative process. Additionally, a cross-disciplinary, collaborative team approach is necessary to integrate knowledge, experience with the person's circumstances, and different areas of expertise.	*Ask participants how their organization is (or could be) supportive of the mortality review process (for example, policies in place, an active mortality review committee, training for committee members, documentation requirements, etc.)*

Script for Instructor	*Suggestions for Instructor*
Slide 4: **Purposes of Mortality Review** Mortality Reviews should be conducted to: ▪ Determine if there are any **red flag** areas that need immediate resolution. ▪ Determine contributing factors of the circumstances surrounding the individual's death. ▪ Identify patterns or trends of concern (areas needing system support). ▪ Determine whether changes are needed to prevent similar circumstances affecting other consumers. ▪ Propose care and treatment recommendations, if appropriate.	
Slide 5: **Designing the Mortality Review System** When designing a mortality review system, some fundamental questions need to be asked: • Why conduct mortality reviews? • How are mortality reviews conducted? • When are mortality reviews conducted? • Who will be involved?	

Script for Instructor	*Suggestions for Instructor*
Slide 6: **Why Conduct a Mortality Review?** The outcome of the review should be a determination of areas where, in retrospect, support for the consumer could have been improved. The committee should pool ideas of recommendations for future changes in the service system. Changes may include such activities as follow-up training for provider and/or regional center staff; training and information dissemination to hospitals, physicians, other care providers; and organizational changes within the provider or regional center. Recommended organizational changes might vary from revising communication systems among providers to establishing a task force charged with increasing the availability of specific services. If the committee identifies a significant issue that requires immediate attention for the health and safety of other consumers, a committee member should be charged with ensuring that the situation is rectified as soon as possible.	*If participants are involved in the mortality review process currently, have them discuss this intended outcome and why or why not their process is successful in meeting it.*

Slide 7: **How are Mortality Reviews Conducted?** Several methods may be used to complete the review process. It is suggested that, prior to the meeting, each committee member reviews the facts surrounding the events to be reviewed. A thorough review should be made of the case history, medical records, and facts surrounding the incident/illness leading to the death, treatment plans, and other relevant records. In addition to medical and nursing issues, residential supports, day services, healthcare utilization, special incidents, and individual planning efforts during the life of the consumer should be reviewed to identify instances where supports might have been better provided. The review should consider information available throughout the life of the consumer but should focus on the previous twelve months to identify: • trends in planning; • use of resources; • deviations from normal health status; and, • limitations or failures of support.	*Ask participants currently involved in mortality reviews to discuss their procedures. You might ask for strategies they think work well in their system or for areas they think could be enhanced.*

Slide 7 (continued) All aspects of the review should be discussed during the committee meeting. If the committee determines that further information is needed, a request should be made to obtain these records and a subsequent review is scheduled. The objective is to examine the impact of all supports on the person's life, not to second-guess the provision of medical and nursing care or to provide a second-opinion of the cause of death. The committee should summarize its findings by identifying areas of concern and making recommendations for any needed follow-up.	

Slide 8: **When are Mortality Reviews Conducted?** Regional centers review all deaths. Consideration should be given to the information on the special incident report (SIR) that would prompt a mortality review. Suggested "triggers" include the following: • High percentage of deaths of unknown origin • Lack of preventative health care • Lack of emergency health care services • Lack of availability of routine health services • Unexpected deaths with one or more of the following conditions: gastrointestinal bleeding, intestinal obstruction, aspiration pneumonitis, malnutrition, decubitus ulcers, cervical cancer, melanoma, diabetic ketoacidosis, tardive akathisia, tardive dyskinesia, or neuroleptic malignant syndrome • All injury-related deaths	

Slide 9: **Who Will Be Involved?** When designing a mortality review process, it is important to determine who should be involved in the review process. Generally, a committee composed of a clinical staff person such as a physician or nurse, or both, completes a mortality review. Some committees include other members who are specifically charged with addressing program planning issues, social issues and relationships, environmental issues, etc. It is also recommended that representatives of the regional center management team such as a service coordination supervisor and quality assurance supervisor be included. A regional center may choose to form a mortality review committee as a sub-committee of the Risk Management, Assessment and Planning Committee. The mortality review committee should meet on a routine basis (e.g., once monthly, twice monthly) depending on the number of cases to be reviewed.	*Ask participants who serves on their committee, if committees are currently being used in their organization.*

Slide 10: **Information Dissemination** Following the review process, recommendations for improvement should be compiled and shared across the entire system. Regional centers will need to consider methods of information dissemination, paying particular attention to confidentiality issues related to the decedents and their families, vendors, and others involved in the person's care and treatment.	*Ask participants what happens to the findings from these reviews. If mortality reviews are not used, have participants list those who should receive, or could benefit, from this information. Lead a discussion on how sharing could be done without compromising confidentiality. Possible solutions could be to: share aggregate results to supervisors such as the number of reviews completed, number and type of recommendations, information available for review, etc.; making aggregate data (altered for confidentiality) available for review by appropriate parties; composing fictitious accounts based on actual reviews that could be used for training.*
Slide 11: **Potential Challenges** What are some problems typically found when completing mortality reviews? • There may not be sufficient information available to conduct a satisfactory review or arrive at definitive conclusions. • Regional centers may not be notified of a death in a timely manner.	

Slide 11 (continued) • Autopsies may not be conducted or reports may not be available, even in situations where the cause of death is unclear. • Death certificates, if available, may list a cause of death that is not included as a diagnosis in pre-mortem records. Despite these possible variables, the process of mortality review can still serve as an enhancement to the delivery of services and supports.	
Slide 12: **Mortality Review** A structured mortality review process is a way to analyze mortality statistics, monitor sentinel health events, and provide qualitative review of individual events. A structured mortality review process results in system-wide quality enhancement.	

Mortality Review

Benefits of Mortality Review

- improved monitoring of quality of care
- development of a mortality database
- improved timeliness of documentation and reporting
- increased attention to quality across all services
- enhanced ability to respond to outside inquiry (licensing, media, etc.)

Organizational Support

- Culture
- Cross-disciplinary team approach

Purposes of Mortality Review

- To determine "red flags"
- To determine contributing factors of the circumstances surrounding the individual's death
- To identify patterns or trends
- To prevent similar occurrences
- To determine whether changes are needed
- To make care and treatment recommendations

Designing the Mortality Review System

- Why Conduct Mortality Reviews?
- How Are Mortality Reviews Conducted?
- When Are Mortality Reviews Conducted?
- Who Will Be Involved?

Why Conduct a Mortality Review?

- Outcomes
- Recommendations

How?

- Collect Information
- Review Life of Consumer
- Identify Issues and Concerns
- Propose Recommendations

When are Mortality Reviews Conducted?

Triggers from Special Incident Reports

Unexpected Deaths

Who?

- Clinical Staff
- Members of Management Team
- Sub-Committee of Risk Management, Assessment and Planning Committee

Information Dissemination

- Recommendations Shared
- Confidentiality Ensured

Potential Challenges

- Sufficient information available
- Timely notification
- Autopsies not conducted
- Death certification information

Mortality Review

System-Wide Quality Enhancement